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December 19, 2007

Congressman Jim McDermott
Chairman
Subcommittee on Income Security and Family Support
Committee on Ways and Means
U.S. House of Representatives

Dear Congressman McDermott,

I am writing in response to your questions related to the hearing before the Subcommittee on Income Security and Family Support on the impact of gaps in health coverage on income security on November 14. Your letter only recently came to my attention and I greatly apologize for missing the December 12 deadline to respond. I sincerely hope that my attached responses are still helpful to you.

Thank you very much for the invitation to testify on this important and timely issue. Please let me know if I can be of further assistance.

Sincerely,

Sara R. Collins, Ph.D.
Assistant Vice President

Attachment

Committee on Ways and Means
Subcommittee on Income Security and Family Support
U.S. House of Representatives
Hearing on "The Impact of Gaps In Health Coverage on Income Security"
November 14, 2007

Responses to Questions from Chairman McDermott

Sara R. Collins, Ph.D.
Assistant Vice President
The Commonwealth Fund
December 19, 2007

1. How does the U.S. spending on health care per capita compare to other industrialized nations? How do basic health statistics compare to other industrialized nations?

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U.S. spending on health care comprised 15.3 percent of gross domestic product in 2005, compared with 9.1 percent in the median Organization for Economic Cooperation and Development (OECD) country (Figure 1). Per-capita spending on health care in the U.S. totaled $6,401 in 2005, twice that of the median for all 30 OECD countries at $2,922.[1] Americans also spend two times as much on out-of-pocket expenses than do residents of other industrialized countries (Figure 2).

The U.S. leads all other industrialized countries in the share of national health expenditures devoted to health care administration. In 2003, spending on health and insurance administration commanded 7.3 percent of national health spending. Similar spending in other industrialized countries ranged from 5.6 percent of national health expenditures in Germany to around 2 percent in France, Finland, and Japan (Figure 3).[2] Davis and colleagues estimate that if the U.S. had a similar level of administrative spending to that of France, Finland, and Japan it would have saved $97 billion on health

[1] J. Cylus and G. F. Anderson, *Multinational Comparisons of Health Systems Data, 2006* (New York: The Commonwealth Fund, May 2007).
[2] C. Schoen, K. Davis, S. K.H. How, S.C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive Sept. 20, 2006, W457-475; The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund) Sept. 2006.

public and private insurance systems, like Germany and Switzerland, would have saved an estimated $32 to $46 billion in that year.

How do basic health statistics compare to other industrialized nations?

The Commonwealth Fund Commission on a High Performance Health System's *National Scorecard on U.S. Health System Performance*, finds that the U.S. health system falls far short of achievable benchmarks and that reached by other countries for health outcomes, quality, access, efficiency, and equity.[4] The Commission found that out of a possible 100 points based mostly on benchmarks that have been achieved within the U.S. or other countries, the U.S. received a score of 66, or one-third below benchmark levels of performance. The U.S. scored particularly poorly on indicators of efficiency, with wide variation in cost and quality across the country and with much higher spending levels than other countries. The U.S. ranks 15th out of 19 countries on mortality from conditions "amenable to health care"—that is, deaths that could have been prevented with timely and effective care (Figure 4). In fact, 115 people per 100,000 Americans die from illnesses amenable to medical care before age 75, compared to 75 to 84 per 100,000 in the top three countries—France, Japan, and Spain. The U.S. ranks at the bottom among industrialized countries on healthy life expectancy at birth or at age 60. And out of 23 countries, the U.S. ranked last on infant mortality, with a rate of 7 infant deaths per 1,000 births, more than double the rates of the top three countries—Iceland, Japan and Finland—and well above the median rate for high-income industrialized countries (4.4 per 1,000 births) (Figure 5).

In a survey of five countries, Schoen and colleagues found that the U.S. had the highest share of adults reporting cost-related problems accessing needed health care (Figure 6). In 2004, 40 percent of U.S. adults and 57 percent of adults with below-average incomes reported they went without care during the year because of cost—four times higher than in the United Kingdom, a country with universal health insurance coverage and other protective policies.[5] In 2005, more than one-quarter (26%) of U.S. adults and more than one-third (36%) of uninsured U.S. adults went to an emergency room for a condition that

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[4] C. Schoen, K. Davis, S. K.H. How, S.C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive Sept. 20, 2006, W457-475; The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund) Sept. 2006.

[5] C. Schoen, R. Osborn, P. T. Huynh, M. M. Doty, K. Davis, K. Zapert, and J. Peugh, "Primary Care and Health System Performance: Adults' Experiences in Five Countries," *Health Affairs* Web Exclusive (Oct. 28, 2004):w4-487–w4-503.

could have been treated by a regular doctor. This is two and three times the rate reported by British respondents (12%) and four and six times the rate reported by Germans (6%).

2. Why must individuals who receive federal disability benefits wait two years before they become eligible for health coverage under the Medicare program?

Federal law requires people with a severe and permanent disability to wait two years after they begin receiving Social Security Disability Insurance (SSDI) before they can be covered under Medicare. The primary reason why Congress applied the two year waiting period was to keep the costs of the program down. [6]

There are an estimated 1.7 million people who are disabled and in the waiting period for Medicare . Of those, about one-third have coverage through a former employer or though a spouse's employer, just over a third are covered by Medicaid, 9 percent purchase coverage through the individual insurance market, and 15 percent, or nearly 265,000 people, are without health insurance. Those with COBRA coverage through a former employer or who purchase it through the individual market are financially burdened with the full premium.

In a 2005 study of older adults, 41 percent of disabled Medicare beneficiaries ages 50-64 said that they had been uninsured just prior to entering Medicare. [7] More than four of five (84%) said that becoming eligible for Medicare was very important.

Prior research has found that people in the two year waiting period who are uninsured experience significant hardship and report skipping or delaying needed health care because of costs. [8] It is critical that we end the two-year waiting period for coverage of the disabled under Medicare. The Lewin Group estimates that the cost to the federal government of immediately ending the waiting period would be about $9.1 billion in 2007, but that figure is expected to decline over time since there would be fewer people

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[6] B.Williams, A. Dulio, H. Claypool, et al. *Waiting for Medicare: Experiences of Uninsured People with Disabilities in the Two-Year Waiting Period for Medicare* (New York: The Commonwealth Fund) October 2004.

[7] S.R. Collins, K.Davis, C. Schoen, et al., *Will You Still Need Me? The Health and Financial Security of Older Americans* (New York: The Commonwealth Fund) June 2005.

[8] B.Williams, A. Dulio, H. Claypool, et al. *Waiting for Medicare: Experiences of Uninsured People with Disabilities in the Two-Year Waiting Period for Medicare* (New York: The Commonwealth Fund) October 2004.

enrolling all at once and less pent up demand for health services from uninsured or underinsured people in the waiting period.[9]

3. Unemployed workers that received health insurance through their employer may be able to continue to purchase their health coverage through COBRA for up to 18 months. Do many unemployed workers continue to purchase insurance through the program? Why are unemployed workers not taking advantage of COBRA?

A significant problem is that a significant share of lower income workers who would benefit from COBRA coverage is not eligible for the benefits. And even when they are, because they must pay 102% of their former employer's premium, many find it unaffordable. Like employer-based coverage in general, lower wage workers are far less likely to be COBRA-eligible than higher wage workers (Figure 7). In a Commonwealth Fund Survey only 40 percent of workers with incomes under 200 percent of poverty had COBRA-eligible benefits compared to 75 percent of workers in households with incomes of 200 percent or more. Kapur and Marquis found that of workers with household incomes of less than 200 percent of poverty who left a job voluntarily, 53 percent were uninsured one-month after leaving their job compared to 28 percent of higher income workers.[10] But 50 percent of lower income job leavers were uninsured prior to leaving their job compared to 22 percent of workers with incomes of 200 percent or more of poverty. Higher income workers who voluntarily left their jobs were somewhat more likely to have COBRA (8% vs. 3%) than their lower income counterparts, much more likely to gain coverage through a new job (16% vs. 4%) and much more likely to gain coverage through a family member's employer (31% vs. 10%)

Even when lower wage workers are eligible for COBRA benefits, the full cost of the premium, now more than $12,000 a year for a family plan, plus the 2 percent fee may be unaffordable, particularly as a share of an unemployment benefit. [11] Kapur and Marquis found for example, that of lower income workers who were eligible for COBRA through their jobs and left their jobs, 48 percent were uninsured one-month later compared to 27 percent of higher income COBRA-eligible workers who left their jobs. Lower income workers and higher income workers took up COBRA at about the same rate (18%) but

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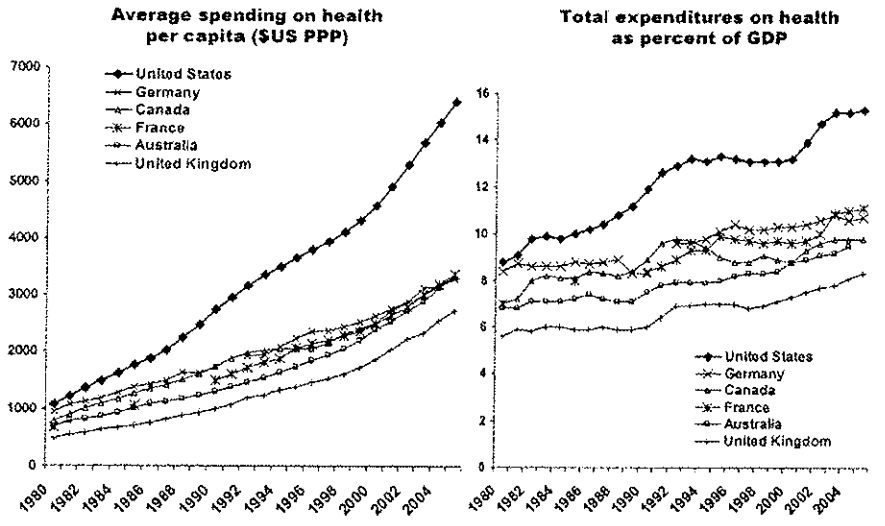
[9] S.R. Collins, K. Davis, J.L.Kriss, *Analysis of Leading Congressional Health Care Bills 2005-2007: Part I, Insurance Coverage* (New York: The Commonwealth Fund) March 2007.

[10] K. Kapur and M.S. Marquis, "Health Insurance for Workers Who Lose Jobs: Implications for Various Subsidy Schemes," *Health Affairs* 22(3) (May/June 2003) :203-213

[11] J.M.Lambrew, *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance* (New York: The Commonwealth Fund) November 2001.

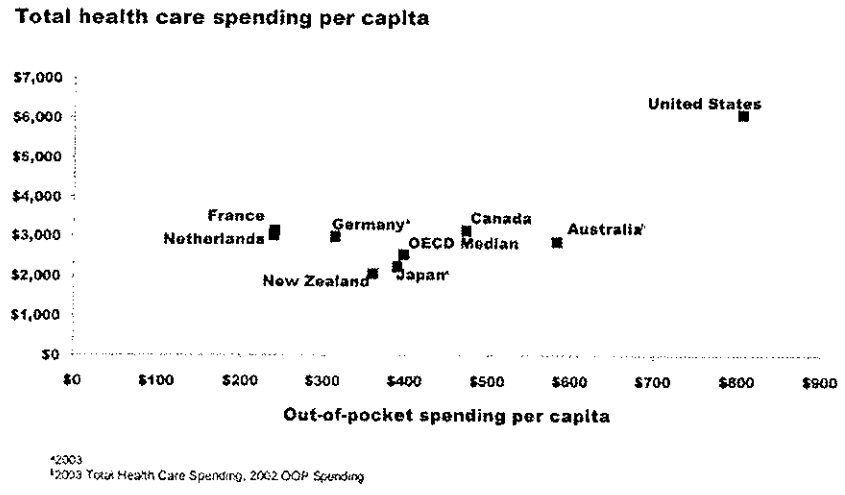
higher income workers were much more likely to have gained coverage through a new job (29% vs. 9%).

Figure 1. International Comparison of Spending on Health, 1980–2005



Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006. Updated data from OECD Health Data 2007.

Figure 2. Americans Spend More Out-of-Pocket on Health Care Expenses

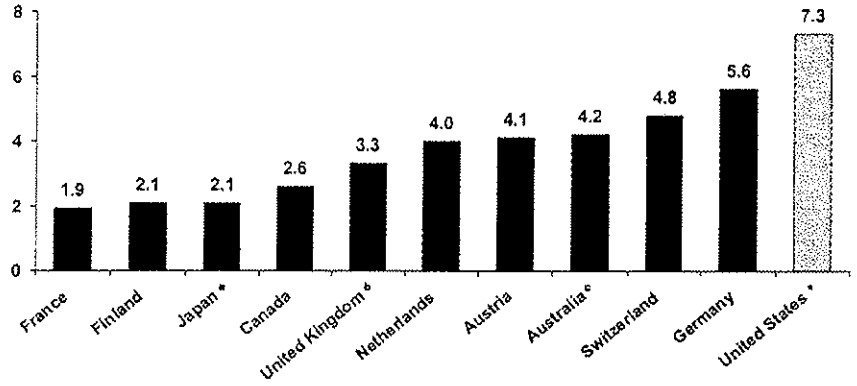


*2003
†2003 Total Health Care Spending, 2002 OOP Spending

Source: The Commonwealth Fund, calculated from OECD Health Data 2006.

Figure 3. Percentage of National Health Expenditures Spent on Health Administration and Insurance, 2003

Net costs of health administration and health insurance as percent of national health expenditures

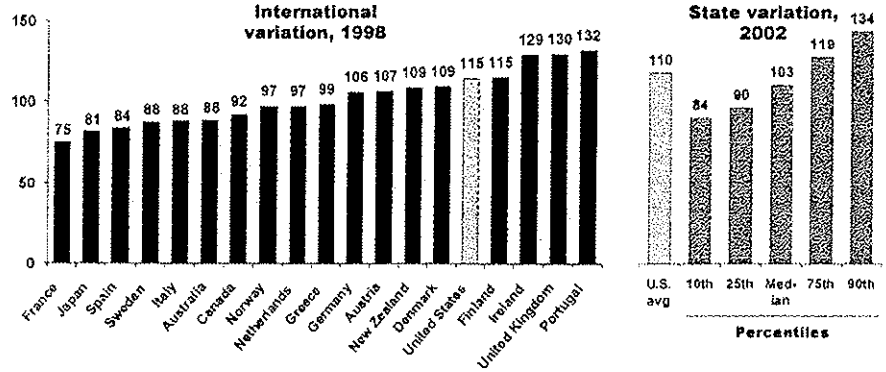


*2002 [b]1999 [c]2001
[a]Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.
Data: OECD Health Data 2005.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 4. Mortality Amenable to Health Care

Mortality from causes considered amenable to health care is deaths before age 75 that are potentially preventable with timely and appropriate medical care

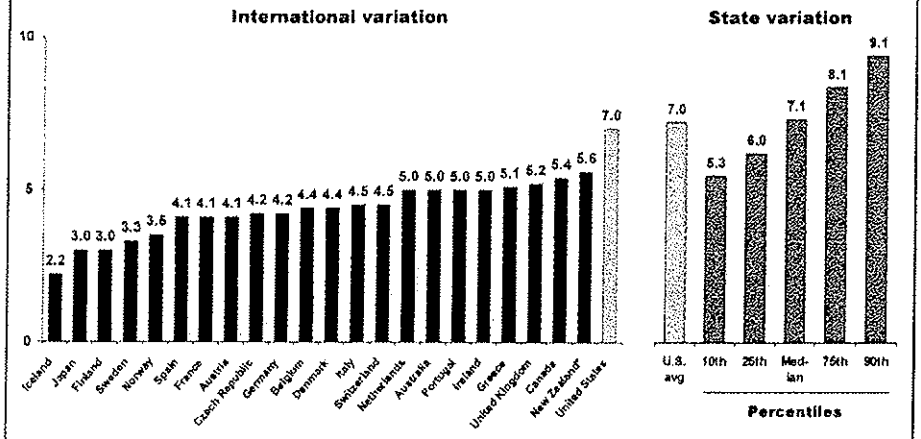
Deaths per 100,000 population*



*Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease.
See Technical Appendix for list of conditions considered amenable to health care in the analysis.
Data: International estimates—World Health Organization, WHO mortality database (Nolte and McKee 2003); State estimates—K. Hempstead, Rutgers University using Nolte and McKee methodology.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 5. Infant Mortality Rate, 2002

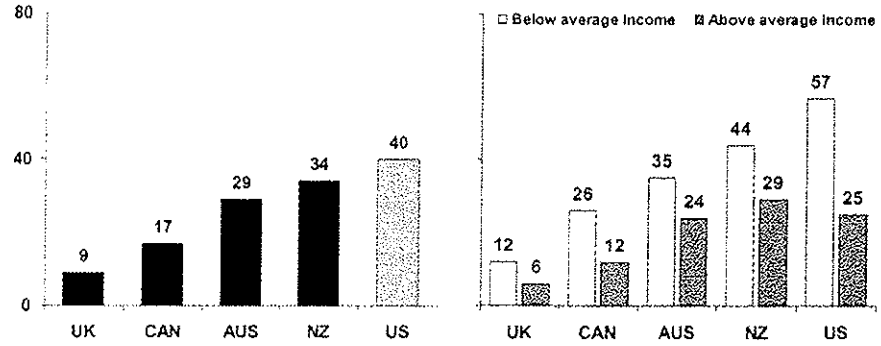
Infant deaths per 1,000 live births



*2001.
Data: International estimates—OECD Health Data 2005;
State estimates—National Vital Statistics System, Linked Birth and Infant Death Data (AHRQ 2005a).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

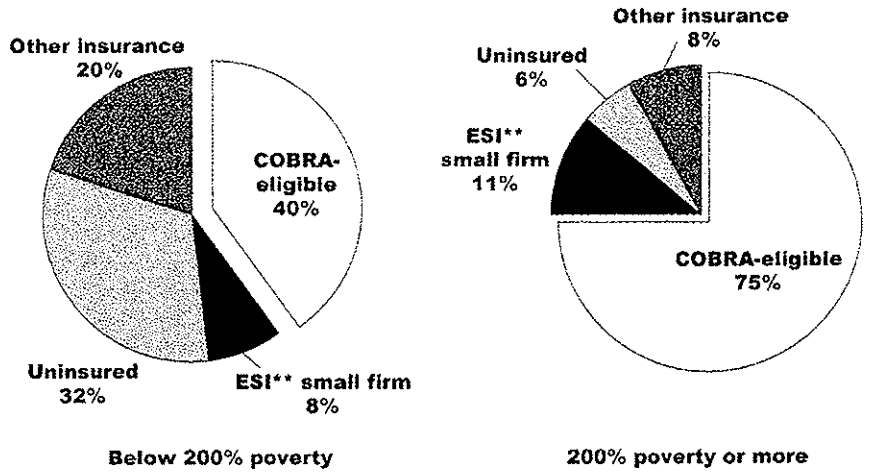
Figure 6. Access Problems Because of Costs in Five Countries, Total and by Income, 2004

Percent of adults who had any of three access problems* in past year because of costs



* Did not get medical care because of cost of doctor's visit, skipped medical test, treatment, or follow-up because of cost, or did not fill Rx or skipped doses because of cost.
UK=United Kingdom; CAN=Canada; AUS=Australia; NZ=New Zealand; US=United States.
Data: 2004 Commonwealth Fund International Health Policy Survey of Adults' Experiences with Primary Care (Schoen et al. 2004; Huynh et al. 2006).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 7. Lower Income Workers Are Least Likely to Be Eligible for COBRA*



* The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to offer continuation of health insurance coverage to former employees. ** Employer-sponsored insurance coverage.
Source: L. Duchon, C. Schoen, M. M. Doty, K. Davis, E. Strumpf, and S. Bruegman, *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk* (New York: The Commonwealth Fund, Dec. 2001).